Supplemental Agreement to Pay
Varying Temporary Partial Benefits

Virginia Workers' Compensation Commission
1000 DMV Drive Richmond VA 23220

SEE INSTRUCTIONS ON REVERSE SIDE

The boxes to the right are for the use of the insurer	Reserved	VWC file number
	Insurer code	Insurer location
	Insurer claim number	

Employer

Name of employer (see Employer's Accident Report)	Address
Phone number / Federal Tax Identification Number	

Employee

Name of employee	Phone number	Cause of injury/ illness
Address	Date of birth	Nature of injury/ illness(incl. body parts)
	Social security number	City or county where injury/illness occurred:
Date of injury or illness / List first seven days of incapacity	Pre-injury Average Weekly Wage	

Varying Temporary Partial

From ________________ through _______________, claimant was paid $____________ per week as temporary partial compensation.
The weekly wage before the injury was $_____________. The weekly wage for this period was $_______________.

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The weekly wage before the injury was $_____________. The weekly wage for this period was $_______________.

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The weekly wage before the injury was $_____________. The weekly wage for this period was $_______________.

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The weekly wage before the injury was $_____________. The weekly wage for this period was $_______________.

From ________________ through _______________, claimant was paid $____________ per week as temporary partial compensation.
The weekly wage before the injury was $_____________. The weekly wage for this period was $_______________.

Employer	Print Name	Phone ( )	Date / /
Signature of Employee, guardian, or committee	Print Name	Phone ( )	Date / /
Insurer or authorized representative (signature of processor)	Print Name	Phone ( )	Date / /
Name of Insurer	(This space reserved for Commission use) Fee		
Name and address of employee's attorney (if represented)	Approved by		Date

FILING INSTRUCTIONS

(Instructions Updated 09/01/07)

Supplemental Agreement to Pay Varying Temporary Partial Benefits VWC Form No. 4G

1. This form is completed whenever additional ***consecutive*** periods of temporary partial compensation occur for an accident or illness for which an initial Agreement to Pay Benefits has already been submitted to the Commission. Submit the completed form to the Virginia Workers' Compensation Commission, 1000 DMV Drive, Richmond , VA 23220. *Note*: If the periods are not consecutive, a Supplemental Agreement to Pay Benefits (VWC Form No. 4A), should be filed.

2. For subsequent periods of compensation benefits, a Supplemental Agreement to Pay Benefits (VWC Form No. 4A) or a Supplemental Agreement to Pay Varying Temporary Partial Benefits (VWC Form No. 4G) must be filed.

3. The information at the top right of the form should be provided by the insurer. Please note that the insurer code refers to the five-digit numeric code assigned by The National Counsel on Compensation Insurance (NCCI). Self-insured employers are assigned a similar five-digit code number by the Virginia Workers' Compensation Commission.

4. Incomplete or illegible forms will either be returned to the insurer for proper completion or they will be rejected.

5. When filling out this form, please be sure to provide a brief description of how the accident or illness occurred in the "Cause of Accident" box. Please indicate **all** parts of the body affected and which are accepted, in the "Nature of Injury" box.

6. Note that compensation is paid beginning with the eighth (8^{th}) day of disability resulting from a work related accident or illness. If the disability period exceeds more than 21 days, then compensation is owed retroactively for the first seven (7) days of disability. The first seven (7) days of disability includes all days or parts of days when the injured employee was unable to earn a full day's wages, or was not paid a full day's wages, due to the injury. These dates should be the same as reflected on the Agreement to Pay Benefits (VWC Form No. 4).

7. When an employee receives full wages during disability, these days are to be counted towards the waiting period and any subsequent days of disability. Agreement forms need to be completed in their entirety, giving dates and amounts the employee would have been entitled to receive in compensation benefits covering all periods of disability.

8. **Definition of Type of Benefit**:
   Temporary Partial (TP) Disability – Injured employee is partially disabled for work, but is entitled to receive compensation for a period of temporary partial wage loss, based upon 66 2/3% (.66667) of the difference between the pre-injury average weekly wage and the post (or current) average weekly wage.* Forms received without specific dollar amounts or those that reflect the word "Various" will be rejected.
   - *Compensation rate is subject to yearly maximum and minimum allowances.
   - *All wage information and compensation rate(s) reflected on the form(s) should be based on ***weekly*** figures.
   - *The previously established average weekly wage should be used when completing this form.

9. The signatures of the employee and a representative of the employer or insurer (including the insurer's name and address) are required. If these signatures are missing, this form will be returned.

10. **Forms**: Additional copies of this form are available without cost by writing to the Commission. This form is also available on the Commission's Website, at www.vwc.state.va.us. Please note that color coding of the forms greatly increases the Commission's efficiency in processing claims, and that any alternative versions of the form you develop yourself require prior approval by the Commission. Address your inquiries to "Forms" at the listed Virginia Workers' Compensation Commission address.

11. For questions or assistance with completing this form, please contact the Awards Unit using the Commission's toll-free number at (1-877) 664-2566.